Washington State
Office of the
Insurance Commissioner

Summary of state and federal mandated health benefits

Certain health care benefits are mandated by either state law, federal law—or in some cases—both. This document contains an overview of the various mandates, which health plans they apply to and whether they are required by state or federal law.

Under Washington law, there are:

- 14 health care services which must be covered
- 3 health care services which must be offered as options
- 10 mandates related to access to providers

In addition, Federal law includes 10 mandates, five of which overlap with state mandates. State law also includes six other provisions dealing with enrollment, continuation of coverage, or other coverage requirements that are not included in the definition of a "benefit mandate."

Also, while there is no specific group mandate for contraceptive coverage, the U.S. District Court in Erickson vs. The Bartell Company ruled that the exclusion of contraceptives from an otherwise comprehensive group health plan was discriminatory under title VII of the Civil Rights Act of 1964. Therefore, group health plans in Washington that provide comprehensive prescription drug coverage must also provide coverage for prescription contraceptives.

Under state law, any legislation proposing a new mandate must contain information regarding the efficacy, and social and financial impact of the mandate.

The chair of the Senate or House health care committee may send the proposed mandate through a Sunrise Review. During this review, they may request that the Department of Health (DOH) examine the proposal. Any request for review must be made no later than nine months prior to the legislative session.

If funds are appropriated, DOH must conduct a review and report to the legislature on the proposal no later than 30 days prior to the legislative session.

Note: The document will be updated as new mandates take effect.

Health plans must cover the following 14 services

* Five additional services must be covered under both Federal and Washington state law.
To view these five, go to page 6.

Health Care Service	Description	Affected Plans
Anesthesia for dental services	Carriers must cover general anesthesia and related facility charges for dental procedure performed in a hospital or ambulatory surgical center, for children under age seven, and other specified individuals.	Group
Chemical dependency	Group contracts must include coverage for treatment of chemical dependency in an approved treatment facility or program.	Group
Colorectal cancer exams and laboratory tests	Carriers must cover colorectal cancer examinations and laboratory tests consistent with the guidelines or recommendation of the United States preventive services task force or the federal centers for disease control and prevention.	Individual and group
Congenital anomalies in children and newborns	Carriers must cover newborn infants from the moment of birth, and the coverage must include treatment of congenital anomalies.	Individual and group
Diabetes coverage	Carriers must cover medically necessary equipment and supplies, education and training for the treatment of diabetes.	Individual and group
Emergency medical services in an emergency department	Carriers must cover emergency services provided in an emergency department if a prudent layperson would have believed that an emergency medical condition existed.	Individual and group
Injuries caused by intoxication or narcotics	Carriers may not deny coverage for the treatment of injury solely because it was sustained while intoxicated or under the influence of a narcotic.	Individual and group
Mammograms	Carriers must cover screening or diagnostic mammography services, if recommended by a physician or Advanced Registered Nurse Practioner (ARNP).	Individual and group
Maternity and drug coverage	All individual health plans, other than catastrophic plans [plans with a deductible greater than $1750] must include coverage for maternity services and prescription drug coverage of at least $2,000 annually.	Individual
Mental Health Parity	All health plans must include coverage for mental health services at parity with other medical and surgical services under the plan.	Individual and Group
Neurodevelopmental therapies	Carriers must cover neurodevelopmental therapies (occupational therapy, speech therapy, physical therapy) for covered individuals age six or younger.	Individual and group

Health plans must cover the following 14 services (continued from previous page)

Phenylketonuria (PKU)	Carriers must cover the formulas necessary to treat PKU	Individual and group
Prostate Cancer Screening	Carriers must cover prostate cancer screening upon the recommendation of the patient's physician, ARNP, or physician assistant.	Individual and group
Women's Health Care Services	Carriers must cover women's health care services, such as maternity, reproductive health, gynecological care, general exams, and preventative services.	Individual and group

Health plans must offer the following 3 benefits to the purchaser

Health Care Service	Description	Applicability
Home health care, hospice	Coverage for home health care and hospice care for persons who are homebound and would otherwise require hospitalization.	Group
Prenatal diagnosis of congenital disorders	Contracts covering benefits for pregnancy, childbirth, or related medical conditions must offer optional coverage for prenatal diagnosis of congenital disorders of the fetus.	Group
Temporomandibular joint disorder (TMJ)	Coverage for the treatment of TMJ	Group

Health plans must include access to the following 10 health care providers

Provider/Service	Description	Applicability
Chiropractic care	Chiropractic care must be offered on the same basis as any other care.	Individual and group
Chiropractic care – Non-referral access	Carriers must permit direct access to a network chiropractor of the enrollee's choice without prior referral.	Individual and group
Dentistry	Carriers must cover services performed by a dentist acting within the scope of his or her license, if the services would be covered if performed by other licensed providers.	Individual and group plans sold by disability carriers
Denturist services	Carriers must cover services performed by a denturist acting with the scope of his or her license if the service would be covered if performed by a dentist	Individual and group

Health plans must include access to the following 10 health care providers (continued from previous page)

Provider/Service	Description	Applicability
Every category of provider	Carriers must permit every category of health care provider to provide the covered services or care, if it is within the permitted scope of practice of that provider.	Individual and group
Optometry	Carriers must cover services performed by an optometrist acting within the scope of his or her license, if the services would be covered if performed by other licensed providers.	Individual and group plans sold by disability carriers
Podiatry/Chiropody	Carriers must cover services performed by a podiatrist/chiropodist acting within the scope of his or her license, if the services would be covered if performed by other licensed providers.	Individual and group
Psychological services	Carriers must cover services performed by a psychologist acting within the scope of his or her license, if the services would be covered if performed by other licensed providers.	Individual and group plans sold by disability carriers
Registered nurses and ARNPs	Carriers must cover services performed by any RN or ARNP acting within the scope of his or her license.	Individual and group
Women's Health Care – Direct Access	Health carriers must allow women direct access to the type of health care practitioner of their choice for women's health care services, without requiring prior referral.	Individual and group

Other coverage requirements (6) not listed in the previous charts**

**These provisions do not fit the definition of a "mandated health benefit" as defined in RCW 48.47.010(7)

Provision	Description	Applicability
Continuation of former family members	Carriers must allow covered persons to continue coverage without proof of insurability if they become ineligible as the result of termination of marriage or death of the primary enrollee.	Individual and group
Conversion contracts	Carriers must offer an option to persons who lose their eligibility under a group plan to continue coverage under a conversion plan. Carriers may not require proof of insurability and may not exclude coverage for preexisting conditions under the conversion plan.	Group

Provider/Service	Description	Applicability
Coordination of Benefits (COB)	Limits the amount carriers may reduce benefits if the contract includes a provision for reduction in benefits due to other coverage.	Individual and group
Coverage at a Long Term Care (LTC) facility after hospitalization	Carriers that provide coverage at a LTC facility prior to hospitalization must provide coverage at the same LTC facility following hospitalization.	Individual and group
Dependent child coverage	Requires continuation of coverage for children who are incapable of self-sustaining employment by reason of developmental disability or physical handicap, who are dependent on the subscriber for support.	Individual and group
Mastectomy, lumpectomy	Carriers may not refuse to issue, cancel or nonrenew a contract because of a mastectomy or lumpectomy performed on the enrollee more than five years previously.	Individual and group

Federal Mandates

*Notes which Federal benefit mandates overlap with Washington state benefits mandates

Mandate	Description	Differences in state mandate
Continuation of coverage ** COBRA	Applies to group health plans maintained by employers who have 20 or more employees. It protects covered employees and their covered dependents that would otherwise lose coverage as the result of a qualifying event by giving them the right to continue coverage for a maximum of 18 to 36 months.	Group contracts must offer the contract holder the option of including a contract provision permitting persons covered under the plan who become ineligible for coverage, the option to continue the plan for a period of time at a rate agreed upon.
Coverage of adoptive children**	Group health plans must provide coverage to children placed with participants or beneficiaries for adoption under the same terms and conditions that apply to natural children, regardless of whether the adoption has become final.	All individual and group plans must cover adoptive children on the same basis as other dependents.
Mental health and substance abuse benefits **	If a large group health plan covers mental health, the annual or lifetime dollar limits must be the same or higher than the limits for medical/surgical benefits.	All large group health plans must cover mental health and substance abuse services at parity with medical and surgical services.

Federal Mandates (Continued from previous page)

*Notes which Federal benefit mandates overlap with Washington state benefits mandates

Mandate	Description	Differences in state mandate
Minimum hospital stays for newborns and mothers** (Erin Act in Washington)	Under The Newborns' and Mothers' Health Protection Act of 1996, group health plans may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a vaginal delivery, to less than 48 hours, or following cesarean section, to less than 96 hours. Prohibits a group health plan from requiring that a health care provider obtain authorization from the plan for prescribing the minimum stay for the mother or newborn.	All plans that provide coverage for maternity services must permit an attending provider and mother to decide on the length of stay. Covered eligible services may not be denied for follow-up care, as ordered by the attending provider in consultation with the mother.
Reconstructive surgery after mastectomy**	A group health plan must provide individuals who are receiving benefits in connection with a mastectomy and who elect breast reconstruction with coverage for: • All stages of reconstruction of the breast on which a mastectomy has been performed • Surgery and reconstruction of the other breast "to produce a symmetrical appearance" • Prostheses and physical complications of mastectomy, including lymphedemas	All individual and group health plans must provide coverage for reconstructive breast surgery resulting from a mastectomy and coverage for all stages of reconstructive breast reduction on the nondiseased breast to make it equal in size with the diseased breast.
Americans with Disabilities Act (ADA)	Disabled and nondisabled individuals must be provided benefits on the same terms with regard to premiums, deductibles, caps on coverage, and waiting periods.	No state mandate
Family and Medical Leave Act (FMLA)	Requires an employer to maintain group health plan coverage for the duration of a FMLA leave at the level and under the conditions that coverage would have been provided if the employee had continued in employment for the duration of the FMLA leave.	No state mandate
Qualified Medical Child Support Orders	Requires group healths plan subject to ERISA to comply with judgments, decrees, or orders that require a group health plan to provide coverage to a participant's child and meet other specific requirements.	No state mandate

Federal Mandates (Continued from previous page)

*Notes which Federal benefit mandates overlap with Washington state benefits mandates

Mandate	Description	Differences in state mandate
Required coverage for certain pediatric vaccines.	ERISA group health plans and group health plans of state and local governmental employers may not reduce their coverage of the costs of pediatric vaccines below the coverage that was provided as of May 1, 1993.	No state mandate
Uniformed Services Employment and Reemployment Rights Act (USERRA)	Gives an employee the right to continuation of coverage under the employer's health plans while absent from work due to service in the uniformed services. Applicable to employee and covered dependents. Provides for immediate reinstatement in an employer's health plan if coverage was terminated as a result of uniformed services and the employee is reemployed following the completion of the service.	No state mandate
Pregnancy Discrimination Act	Group Health plans maintained by employers who have 15 or more employees must provide the same level of coverage for pregnancy as for other conditions, including but not limited to the same deductibles and co-insurance payments. Benefits for pregnancy may not be more or less comprehensive than benefits provided for any other covered condition.	No state mandate. But, see prenatal diagnosis of congenital disorders.

State and Federal Mandated Benefits/Services

14 Mandated Benefits

- Anesthesia for dental services
- Chemical dependency
- Colorectal cancer exams and laboratory tests
- Congenital anomalies in children and newborns
- Diabetes coverage
- Emergency medical services in an emergency department
- Injuries caused by intoxication or narcotics
- Mammograms
- Maternity and drug coverage
- Mental health parity
- Neurodevelopmental therapies
- Phenylketonuria (PKU)
- Prostate cancer screening
- Women's Health Care Services

4 Mandated Benefit Offerings
(optional for the purchaser)

- Home health care, hospice
- Prenatal diagnosis of congenital disorders
- Temporomandibular joint disorder (TMJ)

10 Access Mandates

- Chiropractic care
- Chiropractic care - access
- Dentistry
- Denturist services
- Every category of provider
- Optometry
- Podiatry/Chiropody
- Registered nurses and ARNPs
- Psychological services
- Women's health care – direct access

6 Other Coverage Requirements

- Continuation of former family members
- Conversion contracts
- Coordination of Benefits (COB)
- Coverage at a LTC facility after hospitalization
- Dependent child coverage
- Mastectomy, lumpectomy

Federal Mandates
**Overlaps with State Benefit Mandate Provisions

- Continuation of coverage/COBRA **
- Coverage of adoptive children**
- Mental health and substance abuse parity benefits **
- Newborns and Mothers: Minimum hospital stays ** [Erin Act]
- Reconstructive surgery after mastectomy **
- Americans with Disabilities Act – ADA
- Family and Medical Leave Act – FMLA
- Qualified Medical Child Support Orders
- Required coverage for certain pediatric vaccines
- Uniformed Services Employment and Reemployment Rights Act – USERRA
- Pregnancy Discrimination Act